Health-care disparities

Title XIX Advisory Committee discussion
February 24, 2006

On February 24, the Advisory Committee met to discuss issues involved in health-care disparities and how the committee can best assist the Health and Recovery Services Administration in developing strategies and interventions to deal with them.

Committee members:
Claudia St. Clair, Molina Healthcare
Mark Secord, Puget Sound Neighborhood Health Centers
Eleanor Owens, family advocate
Allena Barnes, consumer representative
Janet Varon, NOHLA
Gerald Yorioka, M.D., WSMA
Blanche Jones, Home Care Association of Washington
Christen Jankowski, Optometric Physicians of Washington
Kathy Carson, RN, Public Health-Seattle & King County

HRSA staff:
Doug Porter, Assistant Secretary, DSHS
Roger Gantz, Director, Division of Policy & Analysis
RoseMary Micheli, DASA, HRSA,

Guests:
Riley Peters, Department of Health
Bob Morrison, Washington Assn. of Community and Migrant Health Centers
Bob Perna, WSMA

Doug Porter *(introducing Dr. Nancy Anderson):* Dr. Anderson has done yeoman's work explaining the problem to people like me and has been looking for an opportunity to put the issue of health disparities on the table.There is something going on out there, we know there are poor results. **There are significant health disparities that aren't explainable by demographics.** The issue is how to articulate this. What can we do? What strategies we can adopt? What more information do we need to collect, and how do we move forward?

Dr. Anderson ran through some possible health conditions that involve clear disparities, along with some possible interventions. (*Slide show attached***)**

Low birthweight:

- The state would save $2 million in first year by eliminating disparities in low birthweight for African American babies

- Native American- low birthrates similar to African American rates

- Hispanic babies – have a very low rate of low birthweight. The lowest rates are among Hispanic women who come here pregnant. Hispanic women born here tend to mirror the African American experience

- Asian babies – birthweights are different in different groups. Overall, we don't have large minority populations so it's difficult to break things down very far.

Obesity:

- Costs related to diagnosis and treatment – approximately 10 percent of Medicaid's total spending is spent on direct medical costs of obisity

- Costly to treat but easier to prevent

Asthma:

- Same kind of relationship with Hispanics, African Americans, other minority populations -- especially around hospitalization expenses

- Asthma estimated to have $240 million in direct medical expenditures for state (not just Medicaid) and $166 million in indirect expenditures -- $37 million in costs estimated for just Medicaid children

- Interventions in the home ...pets, rugs, smoking ... harder to get savings with intermediate, slight asthma...(but some success with HVAC quality vacuums)

- Some early viral infections may leave children more vulnerable to asthma...with all of the antigens, researchers are not yet sure that it's just exacerbation

- WA Asthma Initiative- found asthma is more common in parts of King Cty that are low income and minority

- Exposure issues- mold, smoking

- MAA survey- many ppl had indoor exposure, includes rugs, wood fireplaces and pets

Committee discussion:

The dimensions of the problem:

Kathy Carson-
Odessa Brown- kids with highest utilization due to asthma - dramatic reduction in hospital visits- trained kids to use inhaler

What are the causes? Early viral infection? Not really known

Allena Barnes - Low birth weight can lead to chronic lung disease - this is different from asthma. Low birth weight compounds # with "asthma" – actually this statistic lumps the two together. It's important to consider these separately.

Nancy Anderson-
"The first job is identifying the problem. Health disparities are outcome problems, they tell us where we need to do a better job . The second area is what we're measuring and how it can be used to be helpful.For example, using fee-for-service data for making decisions but having less robust information about what's happening in managed care plans,and ultimately feeding that all back into a way to identify if there's a problem. For example, with low birth weights, let's start to track that data longitudinally so we can take action."

what info do we need?

1) better info on clients' race and ethnicity.
   Doug- also need to find out multiple ethnicities

2) collaborate w CBO's and local orgs who are doing work like this- offer help e.g. Interpreter services to help with home visits (Thayer); info re clients (Krieger- environmental)

   Allena- Headstart and ECAP- we may want to collect their info
   Eleanor- There is a lack of perspective and comprehensiveness- Victimhood
3) Are there better ways to use contractual agreements with health plans to eliminate disparities?

Janet Varon-
"Much of the problem of addressing disparities is related to healthy behaviors, not just medical care. Do clients understand what to do to maintain health? Can we reward providers who help clients understand? We're better off if we can figure out how to reward this kind of communication.

Dave Gallaher - **"**There are some pitfalls . It's very tempting as policy thinkers to think in terms of big numbers and populations, but behind this chart are lots of individuals with lots of individual changes, and some of them have bad bodies. Whether you call them frail or whatever, you don't want to neglect someone because they're born with some disadvantage. It doesn't meant they're less worthy in some way. A woman described the food stamps she was getting and the three kids she was feeding...anything they could stretch out...lot of starch, not getting fresh fruit....Hamburger helper, macaroni and cheese...didn't lead to a lot of healthy food intake."

Janet - "I want to bring us back to the issue of medical care…access to primary care includes access to dental care – there are many people who can't get access to dental care and they are suffering....I believe that access does contribute to disparities...I just want to make sure that as we pursue...these (other ideas)...that we don't forget that access to care is really important... Undoing the 25 percent cut to adult dental care is important. We also know that people cannot get routine orthopedic surgeries. I just don't see how we can be successful without improving access to services that are covered by Medicaid but not available.

Allena – Things can be done to improve Medicaid coverage. My twins were born at 27 weeks. The only way they could get nutritional supplements was in the hospital, but once out of the hospital it was considered "food" and no longer covered. Finally after a year these items became Medicaid-covered allowing children to leave hospital and continue receiving them.

Complications keep me from doing what I could do. These problems could be fixed if I can get dentures that allow me to eat – which I have been trying to do for 10 years. Lack of dentures causes a chain reaction – leading to weight gain, diabetes, kidney problems, colitis. This is happening for me even though I'm aware of what resources exist.

Blanche Jones - From a home health care perspective: What is out there in the community that you can take advantage of? The people that we see a lot, they want to be independent...they are people of color, and they are white people. It's low-income people you are dealing with, and some of the characteristics of different ethnic groups are shared by all these low-income individuals. It's important to teach people to be independent, including the people who are on home care short-term, yet this activity is not covered by Medicaid.

Claudia St. Clair (?) "One of the key things about the community health worker is the ability to take issues to people who can then make decisions...Something is carried

out in HO plans because they have a little flexibility to make those decisions....Can the plan make exceptions that you couldn't get HRSA to make

Dave - “There's lots of information that relates to an individual’s life. Many DSHS clients are not going to be able to afford healthy food, or cook healthy food. Policies may sound good on paper for a population —but when you see their effect on individual people, everybody recognizes they need to be corrected. I think our challenge is to do it right the first time.”

Jerry Yorioka -
Premature death is an important indicator. For example, people walk out of prisons they don't have any health coverage...I'm sure that people with a serious mental issue, that their longevity from birth is different than the average age when death occurs in the rest of the population. We are not collecting enough on Native American mortality and need to take a fresh look at data.

Chris-
Incentives –can DSHS do this? Or do Feds need to review?

Doug-
Too soon to tell. Nancy’s write up indicates we can do most w/out Feds

Kathy-
Include chronic disease management in mgd care contracts?

Claudia-
We can use claims info- Molina pulls names of asthma clients and sends to primary care providers, the provider checks off what the client needs. Molina offers kits that contain free information and educational tools. They offer carseats as incentive for prenatal care. We have claims information from that we can pull using asthma as an example...that information goes to the primary care provider (PCP), but I’m thinking that would raise the best example.

Mark-
plans report health outcomes- HEDIS. Not by race or ethnicity. But Healthy Options is disproportionately people of color. Results are improving. “I do not think, based on my reading of the literature about overall quality improvement, that providing incentives makes a difference with disparities unless you REALLY focus on the disparity.”

Nancy-

suggest look at QI plan by race/ethnicity. But I don't think overall tracking/incentive makes difference in disparityThis rising tide doesn't lift all boats. I think it's one thing to say let's tackle disparities by making sure everybody has a medical home. I think our stats will tell you that we've made all the progress we can just on making Medicaid coverage available and giving more and more low-income people access to health care....and yet we still have the health care disparities between populations. If people perceive provider prejudice, results are worse. In comparing maternal mortality rates, there is a huge disparity- greater than low birth weight.

Jerry
If you had a scholarship for kids undergoing treatment (?),you would automatically be measuring their success. It would help to do screening, have all kids run a mile. I've always wondered about the kids who are non-athletes - they don't get any screening program.

Eleanor
"No one in this country is denied education and yet we don't look at the individuals who complete high school and those who don't, and we don't make the connection about what that costs the public.

▶ "My point is, the difficulty in looking at the big picture. If one is educated about what one has access to and takes advantage of it, then one is in a better position to take advantage of other things."

▶ "A lack of awareness of responsibility -- I'm overstating it again, but it doesn't exist in our system."

▶ "There are a number of references to the chronic care model, redesigning the delivery system to support more proactive interventions, but one thing that hasn't been talked about is incentives and putting responsibility on people receiving the benefits."

Committee discussion:

Related issues:

Eleanor - "We spend an inordinate amount of time in planning and then in training without any followup to see whether it's relevant to what is our goal...which is to use taxpayer dollars to CORRECT a problem! Victimhood is so ingrained in our society that it causes more of what taxpayers pay for. I see it all over - this attitude of 'I'm a victim!' We never link what we are paying for to what we want."

▶ "Who are the primary beneficiaries? It's providers. We should look at who the primary beneficiaries are whenever a dollar is spent."

▶ “Tying together POG process? Activities or suggestions from this work group may be things we cannot fund...but certainly they can be taken back to the POG process where there is a broader forum.

Jerry Yorioka: “I work for the Snoqualmie tribe. Data we have says one thing, but it doesn't seem right. We need help to balance this out I think there's something wrong with how the data was collected.

The idea of a medical home should be a centerpiece for provider behavior...not only should we point people to a medical home, but it's how providers need to see themselves - as a medical home. To improve lifespan, the medical home should be centerpiece, using an integrative care model.

There are also a couple of specific things...we need to act based on facts:

- DOH is using (CDEMS) Microsoft Access program for adaptability program – using this free software, you can have modules put in there to track …. We put modules in there that can be predictive. This could be used for diabetes.

Another thing -- tribes have health care representatives - health-care workers who transport patients. We should be able to access these people. They can haul people into the doctor's office, and we could have workers look in fridge, do nutrition assessment. If able to identify high utilizers, have baseline reimbursement and than pay additional for improvement of chronic situations (pay for performance).

- And work with the rudimentary health-care programs.

Committee discussion:

In search of interventions:

▶ “To the extent that we can find ideas that have already worked.... Everybody in 50 states is thinking about health disparities. If we can look at those and see what's happening, I think we can factor in the behavior components in a way that doesn't damage people's lives."

▶ “There is a whole list of things that need to be done in order to have healthy outcomes. Medicaid could just take part of that and work with it.

▶ “I know from experience that there are things that can make a difference - keeping kids in hospital when they could have gone home but would have faced a safety issue. I know that those kinds of timings can happen.

▶ “Can we identify the frequent flyers, the people with chronic illness…and separate them from the rest?”

▶ Health plans are required to report on certain HEDIS procedures but these are not tracked by ethnicity. If you look at health plans, you have to assume that the results we're seeing year after year are having an effect.

▶ “Does a rising tide raise all boats? If what you come up with as an incentive doesn't work for that client you will miss out.”

▶ “If you do not pay attention to the specific disparities, they will not go away with tracking and treating.”

Nancy -
One approach is to use Navigators (like Native American CHRs). Navigators are members of the target community and they're not afraid or intimidated by the health-care industry. Breast cancer mortality in Harlem -- navigators make a huge difference.Here, Pub Health uses Family Resource Coordinators. Odessa Brown is doing this.
So if you're looking at something for Medicaid to slice off, consider whether we could make this over statewide and see if there's a way to help support navigators.

▶ “We have to realize it's slow, it's not a magic bullet, because there are so many factors to consider.”

Eleanor - “In the 1920s, public health nurses in New York; were extremely effective in public health situations and emergencies, spent much of their time teaching and coaching immigrant families.”

▶ “What intrigues me with the navigators in Harlem and elsewhere in the country–is that they are not necessarily professionals or providers.They’re just people in the community, trying to explain to the health-care provider the specific needs of the client and then they're going back to the client and explaining how the provider can help them.”

▶ “Maybe there's something specific about what the navigators are doing in Harlem that is unique and exportable, and maybe there's an area where we can focus, transporting a solution.

Dave-
focus on a “problem” “In one case, people were surveyed about the way it was delivered as a preservation of culture: Look at our elders, is this what we want? We're going to disappear. And so they worked with the younger people and got the younger ones to work with the elders, and there was a good outcome -- 90 percent clean and sober.”

Doug-
Regarding the medical home idea - we’ve made as much progress as possible given the Medicaid coverage system as it exists. Individuals in community could be used to serve as guides- ‘interpreters’ between patients and providers.

Allena-
Dave’s example- it was delivered as preservation of culture- not as an alcohol treatment program. Elders were involved - that’s why it succeeded.

Kathy -
We do have a number of outreach workers who are supported by HRSA. You can't put getting health care, particularly preventive health care, at the top of your list if you don't have a place to live, you can't put food on the table...That requires us to have more diverse funding, you're only doing this little bit to connect to health care if you don't look at all the other behaviors that get in the way Look at best practices and do something. We have had First Steps – community health workers – but there are financial disincentives. Look at federal Healthy Start – work with women pre-conception and pregnant women. Preconception care: We're not taking advantage of the opportunities to take preventive measures, to address health needs - smoking, infections etc.“The kinds of things that people encountered when they go to that health care...devaluing them, if you don't have trust with the provider, are you going to take their advice? One area might be where we could look at behavior and best practices - this would be place to make a start and see some progress.

Mark’s colleague-
“Should we be partnering with some other places in state government? It can't all be done in this one stovepipe.”

Jerry-
How about a scholarship for kids with asthma to participate in a sport screening? - exercise-induced asthma at schools.

Mark -
Studies by Dr. Ed Wagner at Group Health look at proactive intervention by providers, registries. At the center of that is the concept of patient self-management support. How can we do what we can as care management assistants in improving their health...identifying what they want to work on and supporting that choice...closing the disparities gap. (That) has to be done person by person, community by community. It really comes down to, how can you support the care decisions of that individual?"

▶ "In King County, focusing on diabetes, 6,000 cases... (we) saw some improvement, most dramatic among Native American population."

▶ "The implementation of electronic health records is going to be so critical, and I think that's another piece of it."

Kathy - Community health worker takes person's needs to decision maker. Hope with Healthy Options is that plan will see persons needs and make exceptions. The navigator needs to have influence. If the outreach worker is just another person doing education, it's not going to be as successful. This navigator -- that's not the situation our average outreach worker finds themselves in now. Harlem project worked well because there were resources.
▶ "Look at what's practical and what worked elsewhere. There are 49 other laboratories where other ideas have been tried, so these are recurring themes. I think it would make sense to tap into those and see what has worked well elsewhere. We do need to do due diligence, and make sure the information we get gets fed back into a dashboard of some kind so we can take action on it."

Bob P- we need to identify problems - health disparities are only outcome measures- and track. Less robust info exists in health plans compared to fee for service - need to improve info. Solutions - what has worked well elsewhere?

Care models and care management support: "There are some people who can do self management and some who can't. Is there some measurement tool you can put in place so you can say to one patient, You're really doing a good job, and then say to another, You're not doing so well and you need something different.You need to come over here and let the navigator help steer youThat is really the key -- we don't want to have this one-size-fits-all approach to health care."

Summary/Closing:

Doug: I appreciate the sensible way people have approached this topic. There are a lot of things that we laid out, things we think have promise – need to go onto a two-pager. Adult dental – put that on the table, and look at some of the investments we've pared back. Don't start with clean piece of paper. Look around and see what's working elsewhere, like the navigator program, and make sure we don't duplicate things that are already being done.

Janet asked about POG and budget timing: "I just want to make sure that we don't miss the boat and have a chance to think about ideas and have some time to react with it." Doug replied that the POG process has been at rest during the session, but that it will be picking up, and he noted that the kind of discussion the committee was having "is certainly going to feed that…We've got an update here that this needs to be a priority…a transformational investment…you are already feeding the POG process, whether you know it or not."

Kathy proposed that the committee's workgroup match up with a disparities work group in HRSA. Doug suggested the workgroup also include DOH representatives.

Kathy, Jerry and **Eleanor** all expressed interest in the committee workgroup. **Claudia** thought someone from Molina could be included – she thought it would probably not be her, but that she would ask the plan for advice.

Kathy suggested the committee appoint a main project and contact person for advisory committee representatives.

Janet reminded members that the committee needs new members and that this would be an opportunity to consider racial and ethnic minority nominees, as well as consumer representatives.

Kathy suggested that the committee have some kind of consumer-mentor pairing so that a non-consumer member takes responsibility for his or her counterpart by going over the basic information about programs and making sure that consumer members are up to speed.